In the Supreme Court
OF THE
United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, et al.,
Petitioners,

vs.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, et al.,
Respondents.

On A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF CALIFORNIA DENTAL SERVICE AND DELTA DENTAL PLANS ASSOCIATION AS AMICI CURIAE

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BRIEF OF CALIFORNIA DENTAL SERVICE AND DELTA DENTAL PLANS ASSOCIATION AS AMICI CURIAE

This brief is filed for California Dental Service and Delta Dental Plans Association with the written consent of all parties to this proceeding pursuant to Rule 42 of the Court.

NATURE OF THE INTEREST OF AMICI CURIAE

California Dental Service is a California nonprofit corporation which undertakes to furnish or pay for dental service for its subscribers in return for premiums paid by them or on their behalf. It provides dental care coverage for approximately 4.5 million individuals, largely in California. It is the defendant in *Manasen v. California Dental Services,* 424 F.Supp. 657 (N.D.Cal. 1976) currently on appeal to the Court of Appeals for the Ninth Circuit (Court of Appeals docket nos. 77-1751 and 77-1752). The *Manasen* case is discussed in detail by the Court of Appeals for the Fifth Circuit in its decision below. As such discussion indicates, the two cases present closely related issues, and the decision in the case at bar probably will be dispositive of many of these issues.

Delta Dental Plans Association is an Illinois nonprofit corporation which includes in its membership 43 nonprofit dental service corporations similar to California Dental Service, organized in 42 states and the District of Columbia.

California Dental Service and the other members of Delta Dental Plans Association are the analogues in the field of dental care and insurance to Petitioner Blue Shield of Texas in the field of medical care and insurance. Although practices and the requirements of state law vary considerably from state to state, typically these nonprofit dental service corporations function by means of contractual arrangements with dentists which are similar to the contracts between Blue Shield and pharmacies at issue in the case at bar.

Amici curiae are therefore vitally interested in the central issue now before the Court: Whether the Sherman Act applies to agreements between health insuring organizations and health care providers.

SUMMARY OF ARGUMENT

The purpose of the McCarran-Ferguson Act is broadly to give support to state systems for regulating and taxing the business of insurance. In construing the scope of the "business of insurance", for which the Act affords limited exemption from the federal antitrust laws, due consideration must be given to the extent and purpose of state regulations. State insurance laws and regulations often require health insurers to limit by contract the price charged by providers of health care. Federal health insurance legislation also encourages, and in some instances mandates, controls on the costs of health care. The Court of Appeals' narrow view that the insurer-provider relationship is outside of the "business of insurance" ignores these significant state and federal policies.

ARGUMENT

I. THE PURPOSE OF THE McCARRAN-FERGUSON ACT.

The Court has had several occasions to consider the underlying purpose of the McCarran-Ferguson Act (59 Stat. 33 (1945), 15 U.S.C. §§ 1011-1015). In the first case to consider the Act, *Prudential Insurance Co. v. Benjamin,* 328 U.S. 408, 429 (1946), the Court

held: "Congress's purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance."

Later, in *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 458-60 (1969), the Court considered in depth the history and purpose of the Act, and particularly the meaning of the phrase "business of insurance" in § 2(b) [15 U.S.C. § 1012(b)]. The Court then found that, while the Congressional debates and Committee reports shed little light on the meaning of the words "business of insurance", the meaning is relatively clear in the context of the problems Congress was dealing with. After reviewing the history of the Act, the Court concluded:

Given this history, the language of the statute takes on a different coloration. The statute did not purport to make the States supreme in regulating all the activities of insurance *companies;* its language refers not to the persons or companies who are subject to state regulation, but to laws "regulating the *business* of insurance." Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply. Certainly the fixing of rates is part of this business; that is what South-Eastern Underwriters was all about. The selling and advertising of policies, FTC v National Casualty Co., 357 US 560, 2 L Ed 1540, 78 S Ct 1260 (1958), and the licensing of companies and their agents, cf. Robertson v. California, 328 US 440, 90 L Ed 1366, 66 S Ct 1160 (1946), are also within the scope of the statute. Congress was concerned with the type of state regulation

that centers around the contract of insurance, the transaction which Paul v Virginia held was not "commerce." The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

We will show in this brief that the activity involved here—health insurers'[1] contracts with the providers

[1]The District Court observed in *Frankford Hospital v. Blue Cross of Greater Philadelphia*, 417 F.Supp. 1104, 1106 (D.C.E.D. Pa., 1976), aff'd 554 F.2d 1253 (3rd Cir., 1977), cert. den., 46 U.S.L.W. 3218: "Blue Cross is not an insurer in the classic sense of that term. In its contracts with subscribers it agrees to furnish them needed health care services in return for premiums paid by them, or on their behalf (e.g., by employers). In order to carry out these obligations Blue Cross contracts with eligible hospitals. In a typical situation, a subscriber goes to a member hospital, presents his or her Blue Cross card, and receives health care services and the hospital sends the bill directly to Blue Cross. On the other hand, a patient insured under a traditional, private health insurance policy is billed for the services he receives and is entitled to receive cash indemnification by his insurer in the amount determined by his particular policy." In this brief we nevertheless refer to health service organizations such as Blue Cross, as well as "traditional" carriers, as "health insurers", as both are generally regulated by state insurance laws and are engaged in the "underwriting of risks, the one earmark of insurance as it has commonly been conceived of in popular understanding and usage." *Securities and Exchange Commission v. Variable Annuity Life Insurance Company*, 359 U.S. 65, 73 (1959).

of care—is intimately and inextricably connected to the fixing of rates and to the status of the health insurer as a reliable insurer. To hold that this activity is outside the definition of the term "business of insurance", as used in the McCarran-Ferguson Act, is to deny the basic purpose of the Act, at least as it applies to health insurance.

II. THE REQUIREMENT THAT HEALTH INSURERS CONTRACT WITH PROVIDERS OF HEALTH CARE IS AN INTEGRAL PART OF STATE REGULATION OF HEALTH INSURERS FOR THE PURPOSE OF FIXING OF RATES AND ASSURING THEIR STATUS AS RELIABLE INSURERS.

Most states include special provisions in their insurance laws authorizing and regulating health service organizations. While it is difficult to generalize about the laws of 50 states, state laws regulating health service organizations commonly require that the health insurance organization enter into contracts with providers of services (hospitals, physicians, dentists, pharmacists, etc.) and that these contracts specify the fees or compensation which the providers are entitled to receive, or a formula for determining such compensation.[2]

[2]Alaska Stat. §§ 21.87.140, .150, .190(a) (1966); Colo. Rev. Stat. §§ 10-16-107, -130 (1973); Del. Code Ann. Title 18 § 6304(b)(3) (1975); Fla. Stat. Ann. §§ 641.04(2)(c), (3)(b) (1972), repealed by Laws 1976, ch. 76-168, § 3(3)(2), eff. July 1, 1982 (Supp. 1976); Ga. Code Ann. §§ 56-1705, -1711, -1705a, -1717a, -1718a(3), -1802(7), -1810, -1822, -1823(3) (1977); Idaho Code §§ 41-3403(5), -3408(3), (4), -3415, -3415A, -3416, -3419, -3421(1)(b) (1977); Ill. Ann. Stat. ch. 32 §§ 555 (Supp. 1978), 579, 667, 690.32, 691.31 (1970); Kan. Stat. Ann. §§ 40-1803, -1903, -19b04 (Supp. 1977); Mass. Gen. Laws Ann. ch. 176A § 5, ch. 176B § 4, ch. 176E § 4, ch. 176F § 4 (Supp. 1977), ch. 176C § 5 (1958); Mich. Compiled Laws Ann. §§ 550.503 (Supp. 1977), 550.506 (1967); Minn. Stat. Ann. §§ 62C.02 subd. 8, 62C.16 (Supp. 1977); N.J. Stat. Ann. §§ 17:48-7, :48C-2(d), :48C-15 (Supp. 1977), 17:48A-8 (1963); N.Y. Insurance Law § 254 (McKinney Supp. 1977); Ohio Rev. Code Ann. § 1739.051 (Supp. 1976); Gen. Laws of R.I. §§ 27-19-14 (Supp. 1977), 27-19-7 (1969); Code of Va. Ann. §§ 32-195.23, -195.38 (1973); W.Va. Code Ann. § 33-24-7 (1975).

These state laws regulating the business of insurance and requiring that health insurers contract with providers of health services have at least two purposes. First, the contracts with providers limit the health insurers' liability, thus tending to assure their status as reliable insurers. Second, since the amount which health insurers are obligated to pay to providers of health services obviously is the major cost factor in health insurance, contracts which limit provider charges have a direct and major effect on the rates charged for health insurance.

The first function of provider contracts, assuring the health service organization's status as a reliable insurer, derives from the fact that most health service organizations were formed as nonprofit corporations with little or no capital. "Hospitals by and large agreed to provide services for subscribers even if funds were not available to reimburse the institutions. Doctors who contracted with Blue Shield Plans often assented to similar arrangements."[3] These contractual arrangements between the service plans and providers of health services take the place of the re-

[3]Eilers, *Regulation of Blue Cross and Blue Shield Plans* (1963), p. 239.

serves, which are required of traditional insurers to assure their fiscal reliability.'

This function of agreements with providers is clearly recognized by some state statutes. For example, Article 24 of the West Virginia Insurance Law which governs "Hospital Service Corporations, Medical Service Corporations and Dental Service Corporations" requires that the contracts between these corporations and hospitals, physicians, dentists and other health agencies provide "that in case of a deficit in available funds of the corporation, each participating hospital, physician, dentist or other health agency will, on the basis stated in this section, accept a pro rata share of available funds in full settlement of any bill submitted."[5]

The close relationship between premium rates charged to subscribers or policyholders and contractual rates by which health insurers reimburse providers of health services is highlighted by state court decisions in which premium rate increases were examined for compliance with state insurance laws. For example, in *Thaler v. Stern,* 44 Misc.2d 278, 253 N.Y.S.2d 622 (Sup. Ct., Spec. Term, 1964), a subscriber challenged the New York Superintendent of Insurance's approval of a hospital insurer's premium increase. The New York Supreme Court noted:

> . . . . Nor is it any more reasonable for the Superintendent to attempt to pass upon requested

[4]Eilers, *op. cit.*, pp. 135-6; 239-40; A. Somers and H. Somers, *Private Health Insurance*, 46 Calif. Law. Rev. 376, 508, 513 (1958).

[5]W.Va. Code Ann. § 33-24-7(c) (1975); see also statutes of Alaska, Florida, Idaho, Michigan and Minnesota, *supra*, note 2.

> subscriber rate increases without giving any consideration to the adequacy and reasonableness of hospital repayment rates. The relation between the two is elemental. There would be no need for subscriber rate increases were it not for two factors: firstly, there has been a significant increase in utilization of hospital services by AHS subscribers and secondly; and more importantly, there has been a tremendous increase in the reimbursable cost of hospital services. [253 N.Y.S. 2d at 631]

To the same effect, see *Application of Blue Cross,* 34 Ohio Misc. 29, 206 N.E.2d 305 (1972); *In re Rate Filing of Blue Cross Hospital Service,* 214 S.E.2d 339 (W.Va. 1975).

III. CONGRESS HAS SHOWN THAT IT CONSIDERS CONTROLS ON PROVIDER CHARGES TO BE AN ESSENTIAL ELEMENT OF HEALTH INSURANCE.

The federal government is both a major health insurer and a purchaser of health insurance. Congress, in enacting federal health insurance legislation, has required that health providers agree to limit their charges.

In 1965 Congress enacted the Health Insurance for the Aged Act, Pub.L. 89-97, 79 Stat. 286, 42 U.S.C. §§ 1395 *et seq.* Section 102(a) of the Act, 79 Stat. 309, as amended, 42 U.S.C. § 1395u, provides for the use of "carriers" for administration of benefits. It provides that payments for physicians' services shall be on a reasonable charge basis and that the contracts between the government and carriers "shall provide

that the carrier . . . will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will . . . be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of Section 1395(y) of this Title. . . ." [42 U.S.C. § 1395u(b)(3)]

In other words, if a physician wishes to be paid for services provided to a Medicare beneficiary on the basis of an assignment, he must agree to accept as payment in full the "reasonable charges" determined by the carrier contracting with the Secretary of Health, Education and Welfare. If a physician does not agree to an assignment, which limits his charges to the reasonable charge determined by the Secretary and the carrier, he cannot receive payment from the carrier; payment must be made directly to the individual patient (42 U.S.C. § 1395u(b)(5)).

The Senate Finance Committee, commenting on this provision, stated as follows:

> The committee believes that the use by carriers of certain existing mechanisms and procedures will help in the determination of whether a charge is reasonable. . . . And, where service benefit plans, for payment of physicians' services, serve as carriers under the program, the use of the same agreed-upon fee schedules that are employed in their own programs may be helpful in avoiding the possibility of disputes regarding fees. (Senate Report No. 404, 89th Congress, 1st Sess., 44 (1965))

The Senate Finance Committee also noted:

> . . . . It is your committee's intent that the Secretary shall, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance. The contracts would have to provide that the carrier would take action to assure that the charges and costs of services for which the supplementary plan may make payment are reasonable [*Ibid.*, at 54]

Similar limitations are imposed by the Health Insurance for the Aged Act on payments to hospitals and other institutional providers of health services (42 U.S.C. §§ 1395f(b), 1395x(u), (v), 1395cc).

An example of the federal government's role as a purchaser of health insurance is the Dependents' Medical Care Act, P.L. 84-569, 70 Stat. 250 (1956), 10 U.S.C. §§ 1071, *et seq.*, Title II of which authorizes the Secretary of Defense to contract for medical care for dependents of military personnel "under

such insurance, medical service, or health plans as he considers appropriate . . ." [10 U.S.C.§ 1079(a)]. The Senate Committee on Armed Services, reporting on the bill which led to this Act, noted:

> . . . . The principal new cost that will result from enactment of the bill is that attributable to the civilian care that would be authorized by title II. These cost estimates are subject to basic assumptions, notable of which are . . . (2) agreement by physicians to some type of maximum fee schedule such as that now in use by the Veterans' Administration. Senate Report No. 1878, 84th Cong., 2nd Session, 9 (1956).

We cite these federal statutes, and their legislative history, to indicate that, when Congress has thrust the federal government into the business of insurance, either as an "insurer" or as a purchaser of insurance, it has also recognized that controls on provider charges are an integral and essential part of that business.

CONCLUSION

Viewed in the light of the state and federal legislative background discussed in this brief, the decision of the Court of Appeals for the Fifth Circuit has serious implications. Both state laws regulating the business of health insurance and federal health insurance legislation recognize insurer-provider agreements concerning charges for health services to be an integral part of health insurance. Congress has relied upon "existing mechanisms" including the "agreed-

upon fee schedules that are employed" by service benefit plans to assure that provider charges paid by the federal government would be reasonable. However, state laws authorizing these same mechanisms are threatened with preemption by the Sherman Act and other federal laws, under the holding of the Court of Appeals.

We submit that the Court of Appeals' conclusion that these mechanisms are not a part of the business of insurance was arrived at without sufficient analysis of their critical role. We therefore join with petitioners in urging that the decision below be reversed.

Respectfully submitted,

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April 25, 1978.